

Supporting Students With Eating Disorders:

**Lessons from an audit of UK
eating disorders provision and what
we can do better together**

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First Steps Eating Disorders

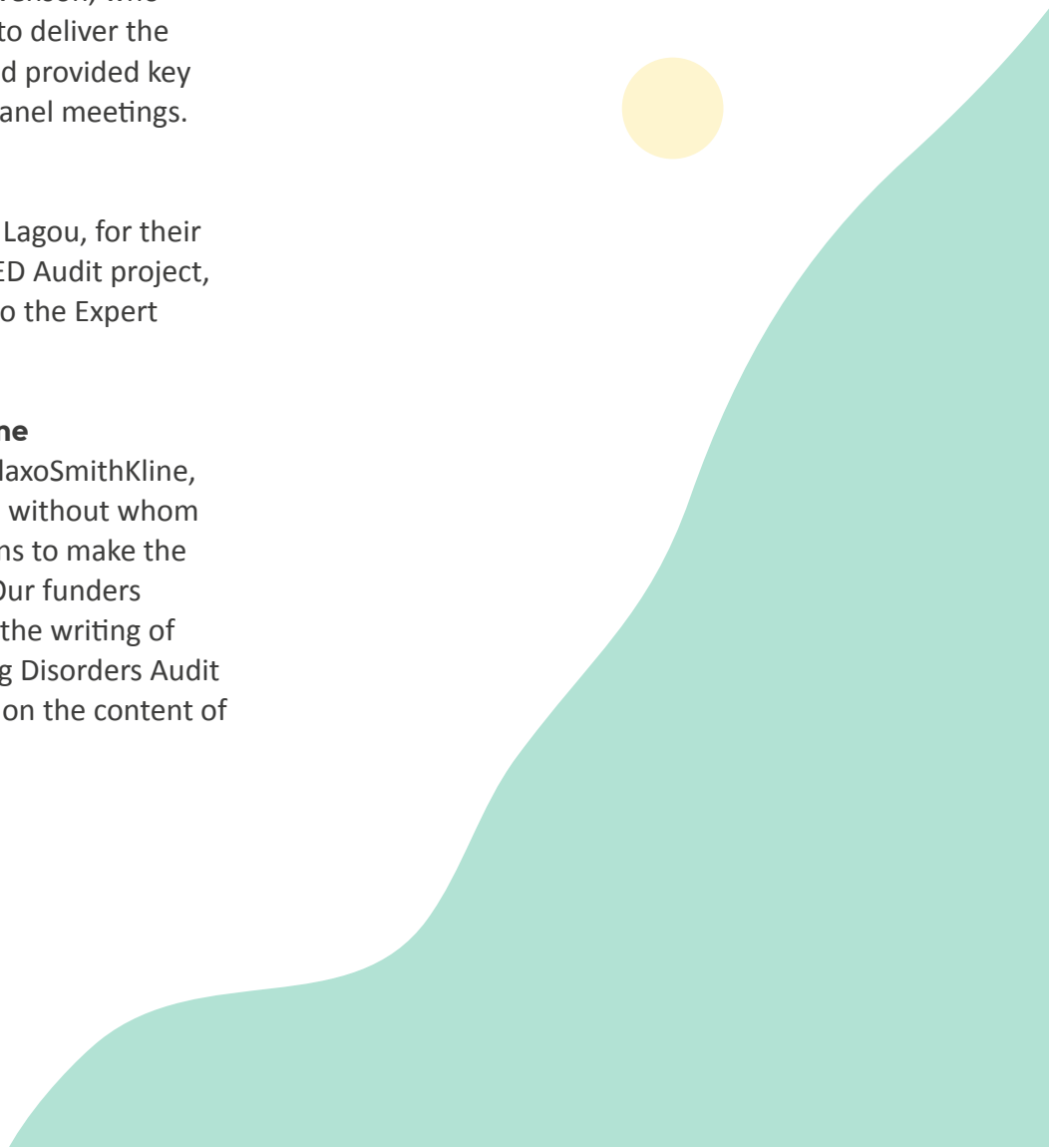
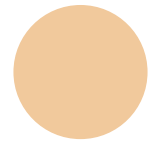
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Our communities

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Our Expert Panel

Our Expert Panel members have provided crucial input throughout the duration of the Eating Disorders Audit project. Their contributions have enriched this report by providing unique perspectives across the higher education, healthcare, and charity sectors. They are:

- Dr. Heike Bartel (Academic Lead for AHRC Network on Male Eating Disorders and Associate Professor in German Studies, University of Nottingham)
- Dr. Nicola Byrom (Senior Lecturer in Psychology, King's College London, and Founder, Student Minds)
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- Antonia Lagou (EDISS Project Manager, First Steps ED)
- Dr. Niamh McNamara (Associate Professor in Social Psychology, Nottingham Trent University)
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- Dr. Hannah White (Lecturer in Psychology, Loughborough University)
- Alice Wilson (Clinical Supervisor, Student Minds, and Cognitive Behavioural Therapist, Birmingham City University, also representing UMHAN)
- Jeanette Youds (Mental Health and Wellbeing Manager, University of Leeds)

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Executive Summary

Transitions

Transitions pose a significant challenge to students with eating disorders by disrupting continuity of care. Namely these include the transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS), the transition into university, and transitions between services at university and home addresses. Effective multi-agency working, including appropriate information-sharing and communication, could help minimise disruption.

Help-seeking and disclosures

Among students, shame, stigma, feeling unworthy of care, and a lack of motivation are all factors that prevented them from seeking support for their eating disorder (Byrom et al., under review). Less than a quarter of people with eating disorders seek treatment (Hart et al., 2011). While significant work goes into facilitating student disclosures for mental health conditions in general, more needs to be done to address the specific needs of students with eating disorders.

Non-clinical staff

Respondents to the ED Audit research thought that university staff ought to be more proactive in engaging students with support (Byrom et al., under review). Particularly for non-clinical staff, more resources are required for them to do this successfully, including training to tackle stereotypes about eating disorders, guidance on maintaining boundaries, recognition in job specifications, pay and benefits, and protected time, among other things.

Stereotypes and health inequalities

Stereotypical conceptions about who gets eating disorders pose a significant barrier to accessing support, notably affecting men, LGBTQ+ people, and racialised and minoritised people. In addition, there is a severe dearth of research exploring the experiences of people with eating disorders who belong to marginalised and underrepresented identities, particularly at the intersection of these groups, and even more so where these people are also students.

Covid-19

Many support providers represented on our Expert Panel either directly experienced a fall in students accessing support during the Covid-19 pandemic, or were aware of falls in demand at services elsewhere. This is in spite of several factors which would threaten to worsen their eating disorder, such as food shortages, social isolation, and disruption of care, and is potentially a consequence of misconceptions about the availability of services during the pandemic.

Recommendations

The report makes a series of recommendations regarding health inequalities, help-seeking, barriers to accessing care, referrals, pathways, and continuity of care, targeted at universities, health care practitioners, and partnership providers.

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Introduction

Although significant progress has been made in the last decade, there are many gaps in existing scholarship on the issue of student mental health, particularly regarding the experiences of students with eating disorders. This report interweaves the findings of an audit into students' experience of accessing support for eating disorders with testimony from our Expert Panel and the wider literature to provide an overview of the key challenges facing students with eating disorders, including within the context of Covid-19 pandemic, and identifies recommendations and areas for further investigation.

We hope this report will serve as a springboard for student mental health advocates, support staff and researchers to better understand the experiences of students with eating disorders and put measures in place to support them at every stage of the recovery process.

Student Minds is the UK's student mental health charity.

Our goal is to transform the state of student mental health so that all in higher education can thrive.

We support students to develop the knowledge, confidence and skills to look after their own mental health, support their peers and create change. We also work collaboratively with institutions, students' unions and other organisations involved in higher education, supporting them to take a whole-university approach to mental health. In addition to providing well-resourced mental health services, a whole-university approach recognises that all aspects of university life should support and promote positive mental health and wellbeing.

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Background



The Eating Disorders Audit

The Eating Disorders Audit was developed out of recognition that the support landscape for students with eating disorders was poorly understood. While students, researchers, and clinicians were aware that gaps in support existed, and were often deeply familiar with the limitations of support available, there was limited scholarship identifying where they were, or how they came about. It was widely accepted that students with eating disorders face a host of unique difficulties at university, however there was a lack of literature accounting for these challenges at a national level. This was a significant barrier to students with eating disorders accessing the support and opportunity for recovery they deserved.

As such, Student Minds, First Steps ED, Dr. Nicola Byrom, and our Expert Panel, came together to identify gaps in support provision. Student Minds and First Steps ED began discussing these issues following both organisations being recognised at the King's Fund and GSK (GlaxoSmithKline) IMPACT Awards in 2017, and we are grateful to GSK for supporting this partnership further by funding The Eating Disorders Audit (ED Audit). The ED Audit brought together the experiences of students and staff from across the country who have experienced eating disorders or supported those diagnosed with them. Our academic partners are pursuing publication of the full Eating Disorders Audit, including analysis of interviews with students in an academic journal.

Throughout the process of supporting the ED Audit, Student Minds has accumulated a wealth of insight, summarised in this report. We synthesised sources such as our Expert Panel meetings with the latest literature regarding the experiences of people with eating disorders, particularly students in a university setting. From this information we draw out a set of policy recommendations and areas for further investigation which we hope will

benefit students, their loved ones, and healthcare practitioners operating across the NHS and Post-16 Education.

We note that while the ED Audit was conceived and developed prior to the Covid-19 pandemic, the pandemic has doubtlessly had an impact on students with eating disorders, and so we have collected what information we have available from our Expert Panel and the academic literature to supplement this resource.

Eating Disorders

Eating disorders are serious mental health conditions where the person who experiences them copes with feelings and situations through their control of food. People from any background, ethnicity, gender or age can have an eating disorder. The DSM-V, a major diagnostic manual used by mental health practitioners to classify mental health conditions, identifies five eating disorder diagnoses, including:

- Anorexia Nervosa
- Avoidant/Restrictive Food Intake Disorder (ARFID)
- Binge-Eating Disorder
- Bulimia Nervosa
- Other Specified Feeding or Eating Disorder (OSFED)

Notably, a person might be diagnosed with OSFED when they do not meet the exact criteria for any of the preceding diagnoses. However, this does not mean that their experiences are less real or serious.

Eating disorders at a glance

- **Prevalence:** Estimates of the prevalence of eating disorders in the United Kingdom vary. Eating disorders charity, Beat, estimate that approximately 1.25 million people in the United Kingdom have an eating disorder (with around 25% of them being male). (Beat, 2021).
 - The most common eating disorder diagnosis in the United Kingdom is Other Specified Feeding or Eating Disorder (OSFED), accounting for approximately 47% of diagnoses. This is followed by binge-eating disorder at 22%, and bulimia nervosa at 19%. Anorexia nervosa accounts for 8% of cases, and avoidant restrictive food intake disorder (ARFID) 5% (Beat, 2021a).
- **Age of onset:** Anybody can develop an eating disorder no matter what their age, and the average age of onset varies depending on which diagnosis a person has. Eating disorders most commonly develop in adolescence, however eating disorders charity Beat reports cases in people ranging from age six to their seventies (Beat, 2021a).
- **Comorbidity:** According to a study of Europeans, over 70% of those with an eating disorder reported a comorbid diagnosis. Of those with a comorbid diagnosis, over 50% had an anxiety disorder, over 40% had a mood disorder, over 20% self-harmed, and over 10% used substances (Keski-Rahkonen & Mustelin, 2016).

You cannot tell somebody has an eating disorder just by looking at them (Beat, 2021a) and as the term “eating disorder” actually refers to a group of diagnoses, two people can be both diagnosed with an eating disorder but experience different symptoms and challenges.

Student mental health

Over the previous decade, poor student mental health has been an issue of growing concern in both the higher education sector and the wider public consciousness. Nationwide prevalence studies concerning student mental health are limited in number, however findings available to us indicate that the prevalence of mental health problems has increased over the last year. As many as 40% of university students may now meet the criteria for a probable mental health problem (Tabor, Patalay, & Bann, 2021).

Among sector leaders the extent of the problem is now broadly acknowledged and this has led to the development of high-level, improvement frameworks such as the University Mental Health Charter (Hughes & Spanner, The University Mental Health Charter, 2019) and Universities UK’s Step Change Framework (2020). These frameworks adopt a “whole-university approach” to student mental health, which takes a holistic look at students and their university experience, rather than seeing mental health as an issue only for support services.

Where the whole-university approach seeks to understand how every person in the university ecosystem can support student mental health, at Student Minds we adopt a similarly holistic view of the circumstances and factors which shape a student’s mental health. We consider material factors such as housing, finances and health inequalities to be crucial in understanding not only how students might become unwell, but whether and how they access support, and how they might get better.

More recently, the wellbeing of students once again became a subject of nationwide discussion in the midst of the Covid-19 pandemic, where images of student halls cordoned off by metal fences and sticky-note window displays captured a generation’s feelings of uncertainty, disappointment and turmoil. The pandemic would

prove to be tremendously disruptive to both the regular functioning of the higher education sector and to National Health Service (NHS) support provision. While every student has been impacted in some way by the pandemic, our “listening” insights, systematically aggregated from social media and thematically analysed, indicate that not every student has experienced the pandemic the same way. Indeed, the Covid-19 pandemic and the associated measures taken to combat it had, and continue to have, a specific impact on people (including students) with eating disorders. We explore their experiences in this report.

The support landscape for students with eating disorders

Students with eating disorders in the United Kingdom may access support from a broad variety of providers throughout their treatment. Potential support providers can include:

- **The National Health Service (NHS):** Students may access eating disorders support through Child and Adolescent Mental Health Services (CAMHS) or Adult Mental Health Services (AMHS) at different stages of their journey through eating disorders support, depending on their age. The transition from CAMHS to adult services is explored later in this report as a key barrier to accessing support for students with eating disorders. The age at which an individual transitions from CAMHS into adult services is typically 18, although it is not fixed. Detailed guidelines, provided by the National Institute for Health and Care Excellence (NICE), provide healthcare practitioners with guidance as to how to facilitate somebody’s transition from CAMHS to AMHS (National Institute for Health and Care Excellence [NICE], 2016).

- **University services:** Some universities provide internal support for students who are experiencing eating disorders. Health and social care practitioners from a wide variety of disciplines may provide support for students within the university, such as disability advisors, mental health advisors, counsellors, and personal tutors. Universities may provide the support to facilitate peer support groups.
- **Students’ unions:** While providing clinical or psychological support is not typically within the remit of Students’ unions, some will provide the resource to facilitate peer support groups, or work collaboratively with their sister institution, local NHS bodies and other third sector providers to promote and signpost their services.
- **Third sector providers:** Third sector bodies, such as local and national eating disorder charities, may provide support to students. Examples of local-level organisations who provide support include First Steps ED, while national-level organisations include Beat Eating Disorders. Third-sector providers variously provide facilitated peer support, cognitive behavioural therapy, occupational therapy, befriending, and other interventions as deemed appropriate.
- **Partnerships:** Much of the support targeted to students with eating disorders is delivered on a partnership basis between a combination of the provider types listed above. For instance, some universities run general practice surgeries in partnership with local NHS trusts, which for many students will be their first point of disclosure or help-seeking.

Students may be referred between multiple services depending on service suitability, their assessed needs, and service capacity. As explored further in this report, the complexity of the support landscape poses a significant barrier to students accessing appropriate support.

Peer Support

Particularly in university and third sector settings, peer support is another support option available to students which enables them to build a sense of community and belonging with others with lived experience of an eating disorder. Providers such as First Steps ED, our partners in the original ED Audit research, provide Peer Support as part of a suite of support options for students under their Eating Disorders in Student Services (EDISS) scheme (First Steps ED, 2021). Our 2014 report, “Peer Support for Student Mental Health”, articulated the benefits of peer support in a university context, including empowerment, social support, empathy and acceptance, reduced stigma, hope, and motivation (Gulliver & Byrom, 2014, pp.4-5). In addition to this, peer support has a number of benefits for the facilitators, such as fewer hospital admissions, turning difficult experiences into something positive, and providing empowerment and self-esteem (Gulliver & Byrom, 2014, p.6). 67% of respondents to the ED Audit said they found peer support helpful, and 100% of students who tried to access peer support had been successful (Byrom et al., under review).

Resource: Peer Support for Student Mental Health (Gulliver & Byrom, 2014)

This report, targeted at universities and students’ unions, provides a well-evidenced account of how peer support works in these contexts. It explores the benefits and different formats of peer support, looks at issues of cost, and identifies existing practice in this space. Crucially, it also provides parameters under which student peer support can be facilitated safely.

Standards of care

The standards for suitable care for people with eating disorders are set by the National Institute for Health and Care Excellence (2020). These guidelines set the standards for the “assessment, treatment, monitoring and inpatient care for children, young people and adults with eating disorders” (NICE, 2020). They are targeted at healthcare professionals, commissioners, other relevant public service professionals (such as those in the education and justice systems), and families and carers. The guidelines outline general principles of care covering topics such as:

- Improving access to services,
- communications and information,
- support for people with an eating disorder,
- working with families and carers,
- consent and confidentiality,
- training and competencies, and
- coordination of care for people with an eating disorder. (NICE, 2020)

Recommendations set out by the guidelines cover both physical and psychological wellbeing, in recognition of the high rates of comorbidity experienced by those with eating disorders. The guidelines also lay out specific recommendations for treatment plans. For instance, for the psychological treatment of adults with anorexia nervosa, the guidelines recommend three treatment programmes for consideration - individual eating-disorder-focused cognitive behavioural therapy (CBT-ED), Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), or specialist supportive clinical management (SSCM). The guidelines recommend that the healthcare professional explains these treatment options to the person with anorexia nervosa and the person can then choose their preferred treatment option.

The guidelines then set the recommended parameters for treatment. For instance, for an adult with anorexia nervosa, the guidelines for individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) are as follows:

- Typically consist of up to 40 sessions over 40 weeks, with twice-weekly sessions in the first 2 or 3 weeks
- aim to reduce the risk to physical health and any other symptoms of the eating disorder
- encourage healthy eating and reaching a healthy body weight
- cover nutrition, cognitive restructuring, mood regulation, social skills, body image concern, self-esteem, and relapse prevention
- create a personalised treatment plan based on the processes that appear to be maintaining the eating problem
- explain the risks of malnutrition and being underweight
- enhance self-efficacy
- include self-monitoring of dietary intake and associated thoughts and feelings
- include homework, to help the person practice in their daily life what they have learned. (NICE, 2020)

In 2019, NHS England issued guidance for the care of adults with eating disorders, which includes an appendix addressing the needs of students in higher education. This information is targeted at healthcare providers to use when commissioning and delivering care (NHS England, 2019).

Specifically, the guidelines address the following areas:

- **Fitness to practice:** The resource draws on existing guidelines pertaining to fitness to practice for students with severe eating disorders, seeking to “facilitate optimal decision making and planning between a CED service, the person and their family, in liaison with other relevant parties (such as university health and wellbeing staff, academic staff, home and university GPs, as appropriate)” (NHS England, 2019, p. 24). It also highlights the need for institutions to be proactive in developing a joint care plan prior to a student’s commencement of, or return to, academic study, and highlights the role of special considerations for students in regulated professions.
- **Starting, and returning to, university:** This includes providing broader transitions support which would be applicable to all students, providing tailored support and guidance pertaining to the specific needs of students with eating disorders (such as shopping, cooking, use of communal kitchens, and social eating), and helping students access support services in their university community.
- **Planning for managing care and transitions in care:** This section pertains to the care a student receives for their eating disorder during university, particularly addressing how the transient nature of student life lends itself to a lack of continuity in care. Specific recommendations include dual registration at permanent and term-time GP surgeries, ongoing contact between a student and eating disorder services at their family address, and (with consent) the implementation of a care plan to be shared with a student’s family and carers.

Key Themes



The ED Audit found only 24% of respondents agreed that “I have been able to access appropriate, sufficient and timely support for my eating disorder” (Byrom et al., under review). Furthermore, only 20% agreed that “[there] are sufficient, appropriate and accessible professional support services for students with eating disorders” (Byrom et al., under review). This section explores factors which influence a student’s ability to access support for their eating disorder in a sufficient, appropriate, timely and accessible fashion.

Help-seeking, initial contact and referral

This report adopts Cornally and McCarthy’s (2011) understanding of help-seeking behaviour as “intentional action to solve a problem that challenges personal abilities” (Cornally & McCarthy, 2011, p. 286), where an individual identifies a problem, decides to seek help from a third-party source (such as a healthcare professional), and explains their problem in return for support. Existing scholarship indicates that help-seeking behaviour is uncommon among people with eating disorders; a 2011 systematic review found that less than a quarter of people with eating disorders seek treatment (Hart et al., 2011).

A separate systematic review in 2017 identified key barriers and facilitators towards help-seeking, with key barriers including stigma and shame, lack of acceptance of the severity of the illness, and lack of knowledge about help resources available, amongst others (Ali et al., 2017). These findings are broadly corroborated by the ED Audit research, where shame, stigma, feeling unworthy of care, and a lack of motivation were all factors preventing students from seeking support (Byrom et al., under review).

Institutional factors also shape students’ willingness to seek help (Byrom et al., under review). Examples of such factors included awareness of accessible services, the availability of services at a suitable time and place, and a lack of privacy in accessing services (Byrom et al., under review). Help-seeking and willingness to access support also vary among subsets of the population - for instance, between men and women, or LGBTQ+ people and cisgender, heterosexual people - we explore this more in the “health inequalities” section.

Finally, Body Mass Index (BMI) and weight were found in the ED Audit to be barriers preventing students from accessing appropriate support. Respondents reported being variously told their BMI was too high or too low for them to access services (Byrom et al., under review). Notably, the NICE guidelines advise that single measures, including BMI, should not be used to determine whether somebody should be offered treatment for an eating disorder (NICE, 2020).

Disclosures

In a 2019 insight brief, the Office for Students noted that higher rates of mental health condition disclosures are associated with higher rates of student continuation through their course (Office for Students, 2019). If, upon transition into university, a student discloses their eating disorder, this creates the opportunity for a pre-emptive referral to support services, or, failing that, contact from such services so that students are aware of support available. Staff at these services can then draw up a support plan, share details of local services for referral, and help identify potential sources of funding to pay for the delivery of the support plan (University Mental Health Advisers Network, 2021). These steps should be followed to minimise the risk of a student with an eating disorder discontinuing their studies.

Resource: The benefits of disclosing a mental health difficulty (Student Minds & UMHAN, 2021)

This blog post, co-authored by Student Minds and the University Mental Health Advisers Network (UMHAN), is a resource for prospective students which talks them through the benefits of disclosing their mental health difficulty on their UCAS application. It is part of a series of blog posts on this topic, which also includes: *Disclosing a mental health difficulty: your rights* (Student Minds & UMHAN, 2021a) and *Disclosing a mental health difficulty on your UCAS application* (Student Minds & UMHAN, 2021b)

Some initiatives to encourage disclosure already exist. For instance, the Universities and Colleges Admissions Service (UCAS), who facilitate the undergraduate (and in some places, postgraduate) student admissions process, explain in their promotional materials how this information is handled, who it is passed onto, what a student's rights are if they disclose, and what the benefits can be. A 2019 Office for Students survey found that over 90% of colleges and universities are encouraging students to disclose their disability (under which definition, mental health conditions can be included) at "any point in the student lifecycle" (Office for Students, 2019, p. 7). The University Mental Health Advisers Network also provides detailed information setting out the benefits and implications of disclosure (UMHAN, 2021).

Despite this, it is estimated that only half of students with a mental health condition disclose this to their university (Thorley, 2017), and we will never know exactly how many students do not disclose due to the very fact they are unknown to their institution. Keeping the average age of onset for eating disorders in mind, it is likely that most students with eating disorders were diagnosed with, or were at least experiencing, their eating disorder, before they arrived at university. Indeed, the majority of respondents to the ED Audit research were diagnosed prior to commencing university study (Byrom et al., under review), and our Expert Panellists reported that a majority of students wanted to disclose their condition to their university, but many of them did not know where to do this (Student Minds, 2020a). As disclosure is a necessary stage in the help-seeking process, it follows that many of the factors which are barriers to help-seeking are also barriers to disclosure.

Transitions and continuity of care

For the purposes of this report, we broadly understand “continuity of care” as described by Gulliford et. al., as a state where a student experiences a “seamless” service (Gulliford et al., 2006), ensured by effective coordination and integration, which will often entail an ongoing clinical relationship with a specific practitioner.

Resource: The University Challenge Report (Hambly & Byrom, 2014)

This report, published by Student Minds in 2014, set out findings from research to “assess the impact of university transitions on access to treatment for students with eating disorders.” Drawing on testimony from students, staff, and parents, the research found that “NHS services are not adapted to the transient nature of student life”. Beyond this, it identified areas of good practice and provided a thorough account of the factors which impeded successful transitions into university for students with eating disorders, and the consequent impact on their mental health. Much of the analysis in the University Challenge Report is still pertinent in 2021, demonstrating the need for a renewed impetus to address the challenge posed to student mental health by the transition into university.

From the University Challenge report, some recommendations which would help facilitate the transitions process and mitigate the knock-on consequences for the mental health of students with eating disorders, include:

- Students should be able to access mental and physical healthcare whether at home or their university address - which means effective communication between these services is vital. (Hambly & Byrom, 2014, p.14).
- Guidelines for funding for the NHS care for transient populations, such as students, must be followed. (Hambly & Byrom, 2014, p.14).
- The tools to safely share information between trusts and services must be improved, to avoid lost information, unnecessary delays, and repetitive, stressful disclosures on behalf of the student. (Hambly & Byrom, 2014, p.15).
- Students (and families or carers where appropriate) should be included in decision-making processes and copied into documentation pertaining to their care, granting them greater agency over their care and allowing easier access to information. (Hambly & Byrom, 2014, p.15).

CAMHS to AMHS transition

The transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS), has significant implications for the wellbeing of people with eating disorders. Factors such as the timing of the transition, clarity of communication and an understanding of differences between services play a significant role in facilitating or impeding a successful transition into adult services (Wales, et al., 2021). In addition to this, as we discuss below, difficulties around locality and registration can coincide with the transition between children's and adults' services to create further delays for a student seeking eating disorders support. This is particularly true of students at college and university who will likely transition to adult mental health services around the same time they will relocate geographically for higher education purposes (NHS England, 2015).

Locality and registration

Students are atypical in that they often split their time between multiple residences. This means that, for months at a time, a student might live at their "permanent" or family address, only to relocate to university accommodation for a similar period, and then back again. Figures from the academic year 2017-18 indicate that roughly 80% of students move between multiple addresses during university study (Whyte, 2019, p. 9). So common is this phenomenon that students are, for instance, able to register to vote at both their term-time and family address.

As a consequence, it is not uncommon for students to be registered with a GP provider at one address while residing in the other, making accessing timely care and referrals into nearby services hugely challenging. Delays in accessing treatment can be exacerbated by the fact that a change in GP provider or residence usually causes further delays in the transfer of care and medical records (NHS England, 2015). The implications of this are severe: students cannot access specialist

services when they are not registered with a GP provider who refers into said services. So, for instance, an incoming student could not proactively seek referral into specialist services at their university address until they actually moved there at the start of term. This creates unnecessary gaps in treatment where students may wait months to access support.

This challenge is then reproduced whenever a student relocates. When a student does receive a referral into a specialist eating disorders service, it may be the case that they have moved to their other address, and are thus unable to access support due to geographic distance. This may in turn lead to their re-referral (thus returning to the bottom of any waiting list) or withdrawal from the service altogether. The difficulties associated with referral, change of address, and long waiting list times create massive discontinuities in care which put a student's recovery at risk and serve as an unnecessary, harmful barrier to accessing support.

Transitions into and through university

The ED Audit found that respondents believe smoother transitions into university would help improve the experience of students with eating disorders (Byrom et al., under review). This backs up previous research into the impact of transitions on student mental health more broadly. In the University Mental Health Charter, many students are noted to experience "psychological distress, anxiety, depression, sleep disturbance, a reduction in self-esteem and isolation" during their transition into university (Hughes & Spanner, 2019, p. 24). Student Minds' University Challenge report also provides targeted recommendations to support students with eating disorders through their transition into university (Hambly & Byrom, 2014).

Acknowledging this as a key area for support and improvement, in 2018 Student Minds published the "Know Before You Go" guide (Student Minds,

2018), an e-resource targeted at Year 12 and Year 13 pupils to help them prepare for the transition to university life. The Office for Students has also recognised the importance of facilitating successful student transitions into university, and at the time of writing £15m in funding had been committed to student transitions and mental health for the 2021-22 academic year (Office for Students, 2021).

Resource: Know Before You Go Guide (Student Minds, 2018)

“Know Before You Go” is a life skills resource that helps Year 12-13 students to anticipate, identify and navigate situations they will encounter when entering higher education. It contains information on many topics including paying bills, study skills, housemate issues, and identity questions. Information on how to maintain good mental health and seek help as needed is embedded throughout.

The “Know Before You Go” guide was adapted by Student Minds with permission from Dr. Stan Kutcher, ONS, MD, FRCPC, FCAHS Professor of Psychiatry and former Sun Life Financial Chair in Adolescent Mental Health IWK Health Centre, Dalhousie University. The original edition can be obtained through teenmentalhealth.org.

The role of non-clinical staff

With respect to accessing support, student participants in the ED Audit identified that they felt universities and university staff ought to be proactive in reaching students with eating disorders, noting that typically the burden lay with them to seek help (Byrom et al., under review). This is where difficulties and barriers to help-seeking, as discussed prior in this section, may arise. It is worth noting that many of the students responding to the ED Audit had specialist treatment plans in place prior to moving to

university; they had already jumped through the help-seeking hoops. The disjointed transition to university meant that these young adults needed to go through the challenging help-seeking process anew, being proactive about seeking out support. This process would not have been necessary if they had not moved to university and shifting the onus onto the individual to seek help contradicts the recommendations around supporting smooth transitions between services (Byrom et al., under review).

Where a student has disclosed an eating disorder, the university must then take proactive steps to follow up and ensure that appropriate support is in place. However, students who do not disclose are still deserving of support, and institutions must navigate these instances sensitively and appropriately. This is especially relevant with mind to the ED Audit finding that students want university staff to be more proactive in engaging them on the topic of their mental health. This proactivity can be facilitated by empowering academic (and other non-student services) staff to create opportunities for students to communicate and reach out if they are struggling. This, in turn, requires that students feel seen as individuals with personal familiarity by university staff. When staff and students have good working relationships, this creates a safer environment for a student to raise personal difficulties.

The role of non-clinical and non-therapeutic staff, such as academics and personal tutors, in student mental health is often poorly defined. It is understood differently amongst students and staff alike, and is typically not supported through appropriate training, effective signposting processes into support services, or clearly-defined job descriptions (Hughes et al., 2018). In order for there to be a reasonable expectation that academic and non-clinical staff might be able to facilitate these conversations, it is only fair that they are enabled to do so with the appropriate tools and training. A number of factors will influence a staff member’s knowledge, confidence,

and skills in starting such a conversation with a student. For instance, staff may be worried about causing offence or harm due to a lack of understanding, or that they may inadvertently become overly involved in supporting the student. Our 2018 report, *The Roles and Experiences of Academics* (Hughes et al., 2018), discusses the role of academic staff in relation to student mental health in depth, and explores some of these concerns in more depth. It should provide structure to help institutions empower staff to act proactively when supporting students with an eating disorder.

Resource: The Roles and Experiences of Academics (Hughes et al., 2018)

This 2018 Student Minds report explores the role and experiences of academics in supporting student mental health. It provides a host of recommendations as to how universities can support academic staff to, in turn, support student mental health, which can provide a framework for doing so in the context of eating disorders.

Some of the recommendations from the report include:

- The time cost of supporting students' needs should be accounted for by universities when planning workloads.
- Academics should receive more comprehensive support and training to appropriately signpost students to relevant services.
- Regular communication between student services, academics and universities should increase in order to create structure and a shared sense of purpose.
- Managers should be equipped with the resources and skills to support their team to appropriately support student mental health, while maintaining boundaries.

It is likely that many of these recommendations will also be applicable, at least to some extent, to non-academic, non-clinical staff. Providing wider university staff with the knowledge, confidence and skills to support student mental health, with appropriate boundaries and sensitivity, is in line with a wider whole-university approach.

Health inequalities

For this section we understand health inequalities to be “structural, personal or cultural inequalities” (Hughes & Spanner, 2019, p. 70) which influence a student’s experience of accessing support for their eating disorder. Evidence from our Expert Panel and the wider literature suggest that people of differing genders, ethnicities, sexual orientations, nationalities, and other identities, experience eating disorders differently. This is the case from early intervention, through to help-seeking, referral and diagnosis, onto treatment and recovery.

The stereotypical conception of people who get eating disorders as white, straight, female and affluent, prevents those who come from different backgrounds from acknowledging and seeking help for their eating disorder (Beat, 2019). This is a commonplace phenomenon across the groups discussed in this section which stops unwell students from accessing the support they need. Higher education institutions and healthcare providers can play their part in tackling these stereotypes by thinking about who their marketing and information materials are targeted towards, and by ensuring staff are trained to understand that any student could have an eating disorder.

Underpinning findings throughout this entire section is the need for further investigation into the experiences of people with eating disorders who belong to multiple marginalised identities. Burke, et al. highlight the potential of intersectional research in this space, noting that “[given] the success of intersectionality-informed research in other areas of psychopathology and its relevance to ED as suggested by initial research, the continued pursuit of these approaches in EDs has high potential to improve identification and treatment for patients who have too often been overlooked” (Burke et al., 2020).

Furthermore, another commonality across the groups discussed is a sense of not belonging within existing eating disorders support structures, whether due to stereotypical notions of who eating disorders affect, or a lack of cultural competency in care. The role of student-facilitated interventions led by those with lived experience, such as peer support, could be significant here in giving these students a sense of belonging (Hughes and Spanner, 2019, p.54) and care that reflects their specific perspective and needs.

Male students

It is estimated that approximately one quarter of people who experience eating disorders are male. However, in the cultural context of the United Kingdom, eating disorders have been coded as female and feminine. This means that men are less likely to both recognise that they have an eating disorder, and also to seek help even when they recognise that they have one (Grillot & Keel, 2018). In April 2020, our Expert Panel noted concerns that as media coverage surrounding the experiences of people with eating disorders in the pandemic centred on women and girls, men and boys with eating disorders would feel less worthy of help or even not acknowledge their condition (Student Minds, 2020).

Eating disorders often present differently in men as they do in women, centring on an ideal of “muscularity” (Murray, et al., 2017). The classifications of eating disorders that currently exist are more representative of eating disorders as experienced by women, leading to the “marginalisation” of men with eating disorders in research and clinical practice (Murray, et al., 2017). This may provide an additional explanation as to why men engage less with eating disorders support than women. Beyond stereotypical notions of who can get an eating disorder, it could also be the case that the causes, symptoms and experience of eating disorders as represented by support services only reflect the female experience, thus indirectly telling male students

that such support is not for them (Murray, et al., 2017). Preconceptions that support will be designed with a specifically “female” experience in mind could be sufficient to stop male students from accessing support.

LGBTQ+ Students

There are multiple, intersecting subgroups within the LGBTQ+ student population, who have broadly different experiences of eating disorders. For instance, gay and bisexual men are more likely to experience disordered eating than straight men, although a similar pattern was not identified between lesbian and bisexual women and straight women (Feldman & Meyer, 2007). Lesbian women were found to have lower body dissatisfaction than their straight counterparts and to report a higher ideal body size (Feldman & Meyer, 2007). Meanwhile, sexual minority males have increased levels of body image dissatisfaction (McClain & Peebles, 2016).

2019 research by eating disorders charity Beat found that “37% of lesbian, gay or bisexual respondents said they would not feel confident seeking help, compared to 24% of straight people” (Beat, 2019).

LGBTQ+ students are exposed to additional risk factors, compared to their cisgender, heterosexual friends, which may increase their likelihood of developing poor mental health. Potential risk factors here include experiences of bullying, discrimination, pressure to conform to sexual and gender norms, shame, and being unable to talk about their experiences (Smithies and Byrom, 2018, p.12). Understanding and mitigating these factors could potentially reduce the likelihood of LGBTQ+ students developing eating disorders, minimise the severity of their symptoms, and improve their likelihood of recovery. For instance, a sense of connectedness to the “gay community” reduces the likelihood of having a current eating

disorder among lesbian, gay and bisexual men and women, while attending a gay recreational group was linked to higher rates of eating disorders among gay and bisexual men (Feldman & Meyer, 2007; Beat, 2019).

In transgender students, pressure to conform their appearance to their gender identity could trigger body dissatisfaction and dysphoria, which in turn could trigger disordered eating behaviours (Testa et al., 2019; Arcelus et al., 2018). A study of transgender youth in Canada (aged 14-25) found that those with the highest levels of enacted stigma and no protective factors were more likely to develop an eating disorder (Watson et al., 2017). Protective factors such as family connectedness, school connectedness and caring friends were linked to lower odds of disordered eating in the past year (Watson et al., 2017). Other factors which cause eating disorders in transgender people include discrimination-based stress, lack of gender-affirming treatment, “hyper-scrutiny” of transgender bodies, and safety concerns such as the need to pass (Malina, 2021).

There are numerous, identified gaps in the literature concerning the experiences of LGBTQ+ students with eating disorders. Much of the evidence here concerns the experience of LGBTQ+ people, rather than LGBTQ+ students specifically, due to the lack of research into the latter’s specific experiences. This includes research across the lifespan of people belonging to a “sexual minority” (Calzo et al, 2017), among LGBTQ+, ethnic minority students, and among male LGBTQ+ students. There has also been minimal research into the experiences of transgender people with eating disorders, let alone transgender students; this is another area which also requires further investigation.

Resource: LGBTQ+ Student Mental Health Report (Smithies and Byrom, 2018)

Published by Student Minds, this report explores the experience of LGBTQ+ students, recent graduates, university staff and students' union staff. It identifies nine key recommendations to improve their mental health, including a recommendation to dedicate further research and support to LGBTQ+ students experiencing eating disorders. The wider report explores topics such as peer support and cultural competence, and these considerations will of course be pertinent in conversations regarding eating disorders among LGBTQ+ students.

Racialised and minoritised students

Research from Beat found that only 52% of BME respondents with eating disorders felt confident in seeking help from a health professional, compared to 64% of white British respondents (Beat, 2019). A 2021 study found that despite being more likely to experience poor mental health, BME students are less likely to access university counselling services than their white peers (Olaniyan, 2021). In a study of college students in the United States, white students with eating disorder symptoms were more likely than their BME peers to receive a diagnosis of an eating disorder, and BME students were significantly less likely to have been asked about eating disorder symptoms by their doctor (Sonnevile & Lipson, 2018). Acculturative stress, perceived discrimination and investment in appearance ideals have been correlated with higher levels of eating disorder symptoms among ethnic and racial minority populations, while "positive ethnic identity" - a sense of positive affiliation with one's ethnic or racial

background - may be protective (Rodgers et al., 2018; Kwan et al., 2018).

There is a seriously limited body of targeted research into the experience of black and minority ethnic (BME) people with eating disorders, even more so regarding racialised and minoritised students. Where research exists, it is often situated in an American context, where dynamics of institutional and structural racism can manifest differently than within the United Kingdom. As such, there needs to be further investigation into the experiences of racialised and minoritised students with eating disorders in a United Kingdom higher education context, including the causes, symptoms, treatment and prevention of eating disorders. In addition to this, more work needs to be done to understand the experiences of these students with eating disorders with intersecting identities, such as those who are male, LGBTQ+, or international students. Furthermore, the experiences of BME students are not monolithic and eating disorders are likely experienced differently by students belonging to different minority ethnic groups (Rodgers et al., 2018); this nuance must be taken into account in research, the development of services, and the delivery of services.

Albeit small, the body of research investigating the mental health of racialised and minoritised students is growing. An analysis of narratives provided by 32 BME university students found that "ethnic minority service users experience overt discrimination and a lack of access to culturally appropriate services that are cognizant of the racialized plights faced by BME individuals" (Arday, 2018). The Black Student Wellbeing study is seeking to understand how to address gaps in service provision for Black university students in the United Kingdom and identify how institutional and structural racism affect their mental health, wellbeing and outcomes (Stoll, 2021). Wider research into BME student mental health is crucial as it contextualises any understanding of the experiences of racialised and minoritised students

with eating disorders in particular. This research, in turn, should underpin our efforts to ensure these students access the eating disorders support they need and deserve.

International students

In April 2020, our Expert Panel noted that their services were having difficulties reaching and providing support for international students during the Covid-19 pandemic (Student Minds, 2020). This was especially the case when students had left the country and either time zone differences or unreliable internet access meant that even remote contacts were difficult to facilitate.

Interestingly, testimony from our September 2020 Expert Panel meeting suggested that international students who access mental health services (such as First Steps ED) or who otherwise engage with mental health charities (such as Student Minds) go on to challenge stigma or specific dynamics in their country of origin which they find detrimental to their mental health (Student Minds, 2020a). Students are experts by experience, and so it is crucial that the experiences of international students are centred when discussing their care, including in the context of eating disorders.

As such, it is encouraging that international students are tackling the issue of eating disorders through their own cultural lens and on their terms. Researchers, policy makers, and anybody interested in best practice in this space should proactively seek to co-produce culturally competent signposting, promotional materials, information resources, and treatment strategies which are resonant to a student's lived experiences and context. International students must also not be treated as a monolith - their nationality, and indeed other aspects of their identity, such as gender and age, will also influence how they see their eating disorder, seek help, and engage with treatment. As with the student groups discussed prior, limited scholarship exists concerning the experiences of international


students with eating disorders in the United Kingdom, and so this is an area which requires further investigation.

Comorbidity

Treating people with comorbidities has been identified as an existing gap in the NICE guidelines for eating disorders treatment (National Institute for Health and Care Excellence, 2017). The ED Audit found that for students who had comorbid diagnoses, their comorbid condition could complicate the process of accessing specialist support (Byrom et al., under review). This appears to happen where comorbid mental health problems are complex, while more common comorbidities are more easily accommodated for. It is essential that services take a joined-up approach to supporting young adults with complex mental health problems, who are too unwell to be expected to cope with being passed around multiple services.

The Impact of Covid-19

This section combines the wider academic literature surrounding the experiences of those with eating disorders with our own insights and case studies pertaining to the university context.

The background of the page features large, abstract, organic shapes in yellow, pink, and blue. The yellow shape is the largest and most prominent, occupying the upper and middle sections. The pink shape is located in the lower right corner, and the blue shape is in the lower left corner. The overall aesthetic is clean and modern.

Food access, insecurity, and shortages

For the purposes of this report, we adopt the World Food Summit's definition of food security as "all people, at all times, [having] physical, social and economic access to sufficient, safe and nutritious food to meet dietary needs for a productive and healthy life" (International Food Policy Research Institute, 2021), with food insecurity being the lack thereof.

In the early stages of the Covid-19 pandemic in the United Kingdom, food shortages, triggered by supply-chain disruption and panic buying, made access to food unreliable and inconsistent. For some people experiencing, or recovering from, eating disorders, this proved challenging for multiple reasons. Access to "safe foods", for instance, could not be assured, making it difficult to follow a high-calorie, prescribed, diet (Shah et al., 2020). The disruption of the routine of accessing food - such as by having to queue outside for extended periods, socially distance, and limit oneself to a strict number of items, added an element of distress and anxiety to an already difficult time.

Research from the pre-pandemic context indicates that people were more likely to reach the diagnostic criteria for binge-eating disorder and bulimia nervosa if they experienced high or very-high levels of food insecurity (Lydecker & Grilo, 2019). In individuals without a prior history of disordered eating, food insecurity and starvation was found to lead to troubling behaviours and experiences such as binge-eating and strict, ritualistic eating habits (Cooper, et al., 2020).

One third sector partner on our Expert Panel noted that they saw a 30% increase in demand for their service overnight, following the initial lockdown in March 2020 (Student Minds, 2020).

People accessing the service expressed concerns that their coping strategies were taken away due to food shortages, and were also worried that their families stockpiling food would create a difficult environment to make safe choices around eating.

Disruption to ongoing care and service demand

Research data and service-provider insights paint a mixed picture regarding the impact of the pandemic on the demand for eating disorders support. One study of access to support in Cambridgeshire and Peterborough in the early stages of the pandemic found that, while presentations and referrals dropped in nearly all areas, there was no notable change amongst those with eating disorders (Chen, et al., 2020). A nationwide population study found that primary care contacts for eating disorders support and treatment fell at the onset of restrictions, and had not recovered by July 2020 (Mansfield, et al., 2021). It should be noted that eating disorders were not unique in this regard, and the study found that contacts for a breadth of conditions, from acute cardiovascular events, to asthma exacerbation, and self-harm, fell.

While one of our third sector partners on our Expert Panel noted a 30% increase in demand for their service following the first lockdown (Student Minds, 2020), other panel members, from third sector, university, and NHS partnership services, all observed a fall in service demand in the initial month of the pandemic. Multiple factors were noted to influence this drop, including the belief among students that support services must be closed, or feeling that their condition was not sufficiently deserving of support.

In April 2020, some clinical practitioners on our Expert Panel also noted a drop in referrals from general practitioners (GPs) - often under the

presumption that specialist NHS services were closed at that stage of the pandemic (Student Minds, 2020). This is particularly problematic as the ED Audit found that 97% of respondents were aware that GPs could provide support - more than any other service or provider - and GPs were also the most accessed, with 74% of respondents seeking support through their GP (Byrom et al., under review). This being so, a breakdown in referrals from GPs to specialist services could translate to a considerable proportion of students not accessing the support that they need.

Expert Panel testimony from September 2020 indicated that a considerable proportion of students believed that primary care services remained closed, with some general practitioners working in partnership with higher education institutions (HEIs) noting that they were, anecdotally, the “quietest they had ever been” (Student Minds, 2020a). By contrast, panel members broadly witnessed that university-based counselling services were “overwhelmed” by demand (Student Minds, 2020a).

The panel also discussed how the media focus on the impact of the pandemic on those with severe anorexia nervosa meant that those who were experiencing conditions such as binge-eating disorder, who may not be underweight, may have felt “pushed to one side” and unwelcome to access help. Concerns were shared across the panel that a similar dynamic where eating disorders were framed as women and girls’ issues meant that men and boys would also not seek support due to self-stigma or feeling undeserving. Again, the ED Audit evidenced these concerns, finding that stigma and feelings of unworthiness for treatment were key barriers to students accessing support.

Finally, one third sector support provider in our April 2020 Expert Panel noted that they had cut through their waiting list by 50%, largely as a significant proportion of students accessing their services did not feel comfortable engaging in video calls. This aligns with the ED Audit research,

which found that a lack of privacy was one of the main barriers preventing students from accessing support (Byrom et al., under review).

Throughout the pandemic, students who would have been accessing in-person support for their eating disorder will likely have experienced disruption to their continuity of care. It is likely that, as a consequence of this disruption, some students’ condition will have worsened over this period, leading to a need for more intensive support going forward.

Quarantine, isolation, and social distancing

Social isolation and loneliness have a negative impact on people with eating disorders. Proper observance of quarantine and social distancing measures increased loneliness and social isolation across the population by limiting the means by which people could safely meet or stay in contact with one another. Social isolation and loneliness are known to be risk factors for the development of eating disorders (Levine, 2012), and social support and one’s sense of connection to others have been found to be central to one’s recovery from an eating disorder (Linville et al., 2012).

In addition to this, a significant number of students have experienced increased social isolation during the Covid-19 pandemic. In a November 2020 survey of students, the National Union of Students (NUS) found that 21% of respondents disagreed or strongly disagreed with the statement that “I have sufficient contact, whether in person with people I live with or virtually with others outside my home, to make me feel connected and/or loved” (National Union of Students, 2020, p. 7).

Clinical practitioners from our Expert Panel noted in April 2020 their concern about managing and monitoring their patients while said patients were at home. Challenges they described centred

around whether students and their families were empowered to support the student's recovery at home. For instance, for students who returned to their family address, there were questions of whether they'd have access to weighing scales (which can be triggering for some students with eating disorders), whether their family was aware and supportive of the student's recovery, and whether tensions from living in close confinement with one another could lead to a decline in a student's mental health. However, our Panel also noted that the experiences of students they were in contact with, who had returned home, were actually mixed. For some, being able to be close to their familial support network was beneficial. Students could rely on family members for distraction, space to follow a meal plan safely and without judgement, and for emotional support for their eating disorder and other challenges.

Vulnerability to Covid-19

At the outset of the pandemic, there was a fear amongst practitioners that those who were experiencing severe physical symptoms of eating disorders, such as emaciation, would have compromised immune systems and thus be more vulnerable to Covid-19 (Touyz et al., 2020).

Despite this, scant evidence exists to demonstrate whether those with diagnosed eating disorders were, in practice, disproportionately likely to become severely ill or die as a consequence of Covid-19. The Office for National Statistics (ONS) has published data from the first quarter of 2021 accounting for deaths where patients have had pre-existing conditions (Office for National Statistics, 2021). However, on examination, eating disorders are not accounted for in this data. This is because the pre-existing conditions which were counted were drawn from the ONS' "Leading cause of death" diagnosis list (Office for National Statistics, 2017), from which mental health

disorders are absent. As such, there is a gap in the data reporting process whereby potential deaths involving Covid-19 amongst those who have diagnosed eating disorders will not be counted as such.

It is also possible that outcomes for people with eating disorders who contract Covid-19 will vary based on their specific diagnosis (consider, for instance, bulimia nervosa versus ARFID), or other intervening variables such as body mass index (BMI) or comorbidity. For instance, one might infer that as those with obesity are more likely to die from Covid-19, and those with binge-eating disorder are more likely to be obese, that therefore those with binge-eating disorder are more likely to die as a result of contracting Covid-19. However, in the absence of deliberate investigation in this area, we cannot confirm with confidence whether this is the case in practice, or whether unknown intervening factors influence the relationship between an eating disorder diagnosis and Covid-19 mortality in a counter-intuitive fashion.

Access to vaccination

16-64 year-olds with severe mental illness were assigned to Priority Group 6 according to guidance from the Joint Committee on Vaccination and Immunity (JCVI), enabling them to access vaccinations against Covid-19 earlier than others in their age group. While eating disorders not explicitly named under this category, national eating disorders charity, Beat, noted that:


“People aged 16-64 with severe mental illnesses are now eligible for vaccination against COVID-19, in vaccination priority group 6. The government body JCVI defines severe mental illness as including people with ‘schizophrenia, bipolar disorder, or any mental illness that causes severe functional impairment.’ [...]

NHS England has issued guidance recommending that GPs take a flexible approach to the interpretation of who is eligible under cohort 6, using clinical judgement and taking into account other factors that might put people at risk of COVID-19. [...] Recent guidance has stated that this could include people who are severely unwell with an eating disorder.”
(Beat, 2021)

Where people with eating disorders were found to meet the criteria for “severe mental illness” and thus priority vaccination, so therefore, were their carers.

Policy Recommendations

The ED Audit found only 24% of respondents agreed that “I have been able to access appropriate, sufficient and timely support for my eating disorder” (Byrom et al., under review). Furthermore, only 20% agreed that “[there] are sufficient, appropriate and accessible professional support services for students with eating disorders” (Bryom et al., under review). This section explores factors which influence a student’s ability to access support for their eating disorder in a sufficient, appropriate, timely and accessible fashion.

The background of the page features a stylized landscape. A large, bright yellow circle representing the sun is positioned in the center-right area. Below it, there are rolling hills in shades of orange and blue. The overall color palette is warm and inviting, with a gradient from light orange at the top to a darker orange and blue at the bottom.

Addressing health inequalities and the diversity of experiences

Several key steps can be taken now to ensure that students from all backgrounds feel more empowered to access support for their eating disorder. Far deeper investigation must build on these findings to understand these dynamics and tackle them appropriately, so that every student has equitable access to support and good mental health.

- **Materials discussing eating disorders and support must clearly demonstrate that they are available for students regardless of background.** This can be achieved through a variety of ways. Materials may opt not to use imagery or language referring to any characteristic (gender, ethnicity, age, etc.). Alternatively, they may deliberately represent students from a broad variety of backgrounds. It may also be beneficial to clarify that anybody can have an eating disorder regardless of personal characteristics and background, but also crucially that everybody is deserving of support.
- **Similarly, any staff training (especially for those in non-clinical or non-pastoral roles, who may have less access to training and education in the area) should challenge stereotypical notions of who can experience an eating disorder and what an eating disorder is.** Large-scale mental health literacy programmes pertaining to eating disorders, targeted at students and staff alike, could help address these issues (Mond, 2016).
- **Further research is required into the experiences of students with eating disorders who belong to marginalised identities.** This includes, but is not limited to, racialised and minoritised students, LGBTQ+ students,

international students, and male students, and is particularly needed regarding those who belong to more than one of these groups. Areas needing further inquiry include (but are not limited to) causes, symptomatology, risk and protective factors, help-seeking, barriers to accessing support, treatment options, and recovery. Note that this report has not provided an exhaustive account of the experiences of every student group that might experience eating disorders differently, and these students' experiences deserve to be heard, and understood, to provide them with the best standard of support.

Help-seeking and barriers to access

- Support providers working in partnership, such as within a shared support pathway, should investigate the practicalities and challenges of information sharing, to **ensure data protection obligations are met while also minimising distress to students by avoiding repeated disclosures** (where their informed consent to share data is given). This will support continuity of care and minimise disruption in a support landscape where multiple referrals, transfer of care issues and associated delays (due to changing localities and transition into adult mental health service) are already commonplace.
- Many students are under the impression that intra-university communication is seamless and different departments or services share complete information with each other. This is not the case in the vast majority of instances and leads to students' expectations not being met.
- While information pertaining to support should be readily available, **access to services, whether physical or digital, should be discreet.** Services should confirm with students an appropriate time, space, and means

through which they can conduct their contacts. Some students experience digital poverty or otherwise have a lack of privacy at their home which makes it difficult to access remote support - alternative means of contact must be found where possible.

- **Choice between service delivery options** (such as between digital or face-to-face contact, or peer-support or one-on-one contact) should be facilitated where possible, as the ED Audit reaffirms that different students prefer different support options.
- The ED Audit reaffirmed that the usage of Body Mass Index (BMI) figures and weight can be a barrier to accessing support for students with eating disorders (Byrom et al., under review). In accordance with NICE guidelines, **BMI should not be used as a sole criterion as to whether a student should be referred for eating disorders treatment.**

Referrals, pathways, and continuity of care

- **The recommendations from our 2014 University Challenge report** continue to be relevant in 2021 and **should be implemented by universities, NHS trusts and services, and third sector providers** as appropriate. A selection of these recommendations can be found on page 16 of this report.
- **Support services should communicate key details pertaining to the referral process**, including waitlists, milestones, timeframes, what happens in appointments, next steps, and alternative support options, to students, so that students can form clear expectations and access support in a way that feels appropriate to them.
- **Better multi-agency working between universities, the NHS, and third sector organisations, must be facilitated**, requiring effective communication and information-sharing. Service providers across the support

landscape should proactively update one another on their capacity, service demand, openness to referrals, and waiting times. At point of referral, the initial provider should confirm whether a service they wish to refer a student into is open, if they are in any doubt. This is particularly pertinent through extraordinary circumstances, such as the pandemic, where the presumption of service closure is likely to have needlessly prevented some students from securing a referral.

- **Healthcare practitioners and students should proactively discuss potential changes in living arrangements when preparing a support programme**, identifying alternative arrangements where necessary (such as remote contacts) and ensuring students are aware of the implications of a change in address or GP provider well in advance. This will help ensure that students can access support with minimal disruption while moving between addresses.
- **Non-clinical staff must be given the tools to succeed in more proactively assisting students with eating disorders.** The recommendations of our report on “The Role and Experiences of Academics” (Hughes et al., 2018) report are instructive here.

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